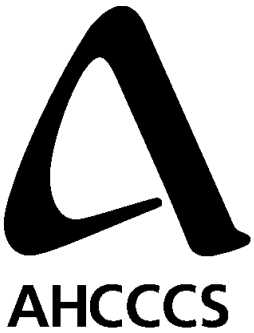
Chapter 5

Billing on the CMS 1500 Claim Form



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A. INTRODUCTION

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500.

1. CPT and HCPCS procedure codes must be used to identify all services.
2. ICD-9 diagnosis codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

B. COMPLETING THE REVISED CMS 1500 CLAIM FORM (02/12)

The revised CMS-1500 health insurance claim form version 02/12 replaces version 08/05. On the new version 02/12 the 1500 symbol at the top left corner is replaced with a scan able Quick Response (QR) code symbol and the date approved by the NUCC.

The revised CMS-1500 version 02/12 will be required effective 4/1/2014. Claims submitted with the old CMS 1500 08/05 form will be returned, regardless of service date.

The following instructions explain how to complete the paper CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

NOTE: This chapter applies to paper CMS 1500 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

1. Program Block — Required

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(ID# / DoD#)*	☐ *(member ID #)*	☐ *(ID#)*	☐ *(ID#)*	☐ *(ID#)*

1a. Insured's ID Number **Required**

Enter the recipient's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)
A12345678

2. Patient's Name **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holliday, John H.

3. Patient's Date of Birth and Sex **Required**

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY		
08	**14**	**1851**	M ☒	F ☐

4. Insured's Name **Not required**

5. Patient Address **Not required**

6. Patient Relationship to Insured **Not required**

7. Insured's Address **Not required**

8. Reserved for NUCC Use **Not required**

9. Other Insured's Name **Required if applicable**

If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number **Required if applicable**

Enter the group number of the other insurance.

9b. Reserved for NUCC Use **Not Required**

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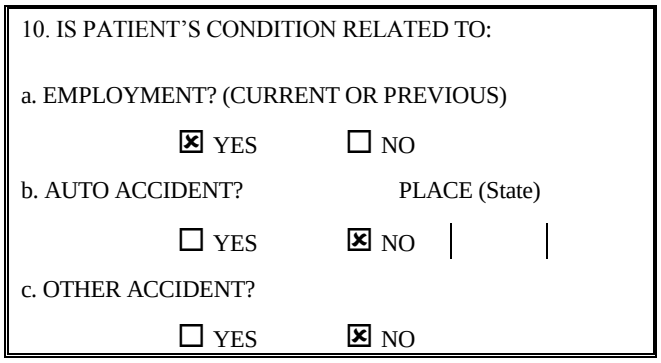
9c. Reserved for NUCC Use **Not Required**

9d. Insurance Plan Name or Program Name **Required if applicable**

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to: **Required if applicable**

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.



10d. Claim Codes (Designated by NUCC) **Not Required**

11. Insured's Group Policy or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Other Claim ID (Designated by NUCC) **Not Required**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Not required**

13. Insured's or Authorized Person's Signature **Not required**

14. Date of Illness or Injury **Required if applicable**

15. Other Date **Not required**

16. Dates Patient Unable to Work in Current Occupation **Not required**

17. Name of Referring Provider or Other Source **Required if applicable**

17a. ID Number of Referring Provider **Required if applicable**

The ordering provider is *required* for:

Laboratory	Drugs (J-codes)
Radiology	Temporary K and Q codes
Medical and surgical supplies	Orthotics
Respiratory DME	Prosthetics
Enteral and Parenteral Therapy	Vision codes (V-codes)
Durable Medical Equipment	97001 – 97546

Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17b. NPI # of Referring Provider

18. Hospitalization Dates Related to Current Services **Not required**

19. Reserved for Local Use **Not required**

20. Outside Lab and ($) Charges **Not required**

21. Diagnosis Codes **Required**

Enter at least one *ICD-9 diagnosis code* describing the recipient's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)			
A. | _____	B. | _____	C. | _____	D. | _____
E. | _____	F. | _____	G. | _____	H. | _____
I. | _____	J. | _____	K. | _____	L. | _____

Relate diagnosis lines A – L to the lines of service in 24E by the letter.

22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A or V	130010004321

23. Prior Authorization Number **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8 Authorizations for information on prior authorization.

24A. Date(s) of Service **Required**

Enter the beginning and ending service dates.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
02	15	13	02	15	13				

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.
(Refer to the Current Procedural Terminology (CPT) manual for a complete place of service listing)

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			Of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
						11			

24C. EMG – Emergency Indicator **Required if applicable**

Mark this box with a "✓," an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

24. A						B	C	D			
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES			
From			To			Of	EMG	(Explain Unusual Circumstances)			
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER		
							Y				

24D. Procedures, Services, or Supplies **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service,* enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

24. A						B	C	D				
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES				
From			To			of	EMG	(Explain Unusual Circumstances)				
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER			
								71010	**26**			

24E. Diagnosis Pointer **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, they should be in descending order of importance.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
		A			
		A, B			

24F. $ Charges **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

24G. Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS coding manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
				3	
				1	

24H. EPSDT/Family Planning **Not required**

24I. ID Qualifier **Required if applicable**

24J. (SHADED AREA) – Use for COB INFORMATION Required if applicable

Use this SHADED field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient' Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount *paid.*

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

See Chapter 9, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

24J. (NON SHADED AREA) – RENDERING PROVIDER ID # Required

Rendering Provider's NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS..

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					COB Information
					NPI Rendering Provider NPI ID #

25. Federal Tax ID Number **Required**

Enter the tax ID number and check the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and check the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	☐	☑	

26. Patient Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.

27. Accept Assignment **Not required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ YES ☐ NO	$ 179 00	$	$

29. Amount Paid **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Reserved for NUCC Use **Not required**

31. Signature and Date **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED John Doe DATE 03/01/13

32. Service Facility Location Information **Required if applicable**

32a. Service Facility NPI # **Required if applicable**

32b. Service Facility AHCCCS ID # (Shaded Area) **Required if applicable**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
Arizona Hospital 123 Main Street Scottsdale, AZ 85252
a. NPI | b. AHCCCS ID

33. Billing Provider Name, Address and Phone # **Required**

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # **Required if applicable**

33b. Other ID – AHCCCS ID # (Shaded Area) **Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
Doc Holliday 123 OK Corral Drive Tombstone, AZ 85999	
a. NPI	b. AHCCCS ID

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